	OF CORRECTION OF CORRECTION 155245	(X2) MULTIPLE CO A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 06/07/2012
	PROVIDER OR SUPPLIER	7630 E	ADDRESS, CITY, STATE, ZIP CODE 86TH ST APOLIS, IN 46256	
(X4) ID PREFIX TAG F0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	This visit was for the Investigation of Complaints IN00108839 and IN00109051. Complaints IN00108839 and IN00109051 substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, and F322. Survey dates: June 4, 6, 7, 2012 Facility number 000149 Provider number 155245 AIM number 100266840 Survey team: Chuck Stevenson RN Census bed type: SNF/NF: 61 Total: 61 Census payor type: Medicare: 11 Medicaid: 41 Other: 9 Total: 61 Sample: 11 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155245		LDING	00	COMPLETED 06/07/2012		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	Quality review of Cathy Emswiller	ompleted 6/11/12 • RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet Page 2 of 26

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155245	B. WING		06/07/2012
			_	T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			E 86TH ST	
CASTLET	TON HEALTH CAR	E CENTED		NAPOLIS, IN 46256	
CASTLE	ION HEALTH CAR	E CENTER	INDIA	INAPOLIS, IN 40250	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225	483.13(c)(1)(ii)-(i	iii), (c)(2) - (4)			
SS=D	INVESTIGATE/F				
	ALLEGATIONS/	INDIVIDUALS			
	The facility must	not employ individuals who			
	have been found	l guilty of abusing,			
	neglecting, or mi	streating residents by a court			
		ad a finding entered into the			
		registry concerning abuse,			
	•	ment of residents or			
		of their property; and report			
		t has of actions by a court of			
	_	mployee, which would			
		s for service as a nurse aide			
		taff to the State nurse aide			
	registry or licens	ing authorities.			
	violations involving abuse, including	ensure that all alleged ng mistreatment, neglect, or injuries of unknown source ation of resident property are			
	reported immediathe facility and to	ately to the administrator of other officials in accordance			
		rough established			
	certification ager	uding to the State survey and			
	Certification ager	icy).			
	The facility must	have evidence that all			
		s are thoroughly investigated,			
	_	it further potential abuse			
		gation is in progress.			
		investigations must be			
	•	dministrator or his			
		esentative and to other			
		dance with State law			
		State survey and certification			
		working days of the incident,			
	•	d violation is verified			
	appropriate corre	ective action must be taken.			
	Based on record	review and interview, the	F0225	What corrective action(s) will be	
	facility failed to	ensure unusual		accomplished for those reside found to have been affected by	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 3 of 26

f '			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED		
		155245	B. WIN	G		06/07/2012		
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	KOVIDEK OK SUPPLIER			7630 E	86TH ST			
	TON HEALTH CAR	E CENTER		INDIANAPOLIS, IN 46256				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG		DATE		
		e reported to the State			the deficient practice: It is this facility's policy to ensure all			
	Agency and thor	oughly investigated as			unusual occurrence are report	ed l		
	required by law	for 3 residents (Resident			to the State Agency and	Cu		
	D, injury of unki	nown origin requiring			thoroughly investigated. Resid	ent		
	1	nt), (Resident K, G-tube			(D) injury is healed and suture			
		ng hospital treatment),			removed. The Administrator,			
	_	gation that men in his			D.O.N., Department Heads,			
		to kill him.) 3 of 3			charge nurses and all staff hav			
		*			been re-educated as to follow facility's Reporting Criteria as t	****		
		ed for reporting of			all resident involved in a incide			
	unusual occurrer	nces in a sample of 11.			or accident requiring			
					sutures must be reported to the	e		
	Findings include	:			proper state agencies. Reside			
					(K) g-tube site has been treate	d		
	1. The record of	Resident D was reviewed			for the diagnosis of cellulitis.			
	on 6/06/12 at 1:1	5 p m			Resident (L) resident was			
	011 07 0 07 12 00 11.1	c p.i.i.			comforted at the time and has			
	Diagnagas inglus	ded, but were not limited			further delusions of two white/of black men in room trying to kill			
	_				him while he was walking on			
		lar disease, vascular	water with Jesus. How other					
		sy, atrial fibrillation, and	residents having the potential to			to		
	hypertension.				be affected by the same defici-	ent		
					practice will be identified and			
	A significant cha	nge Minimum Data Set			what corrective action(s) will be	е		
	(M.D.S.) assessn	nent dated 4/10/12			taken. All residents have the			
	· ′	nt D was cognitively			potential to be affected by this practice. From this point on al			
		t ambulate, required staff			reports or occurances of unusi	I		
		ctivities of daily living,			occurrences will be reported to			
		ent of bowel and bladder.			the State Agency and thorough			
	and was incontin	icht of bower and bladder.			investigated as required by lav	<i>l</i> .		
	NT	Carra da			The Administrator will ensure			
	Nurse's notes inc	iicated:			every staff member is educate	a		
					on the reporting of unusual occurrence and what qualifies	as		
	4/09/12 12:00 p.m. "Res (resident) found on floor bed alarm going off.				an unusual occurrence. What	I		
					measures will be put into place	I		
	Laying on (symb	ool for "left") side of body			or what systemic changes will			
		cm (centimeter) 0.8 cm			made to ensure that the deficie			
	l	,						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 4 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	VIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	TED
		155245	B. WIN			06/07/2	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				86TH ST		
	TON HEALTH CAR	E CENTER			APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	rE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	*	ted on (symbol for "left")			practice does not recur; An		
	eyebrow bleeding	g. Pressure drsg			in-service held June 26, 2012 reviewed the reporting criteria	for	
	(dressing) applie	d stopped bleedingMD			identifying and unusual	101	
	notified N/O (ne	w order) received"			occurrence and reporting an		
	4/09/12 12:30 p.i stretcher to (acut	m. "Res left facility on			unusual occurrence. The DON designee will monitor (10) char weekly to review all nurse's no which might include an unusual event. These monitoring will continue until (4) consecutive		
	hospital on stretc	her(symbol for "left")			weeks of 100% compliance are	e	
	eyebrow has 4 su				achieved. All staff who fail to		
	ey coro w mas i se				report an unusual occurrence		
	4/12/12 indicated bed 4/9 and hit h	oner's Visit Note dated I "Pt (patient) fell out of is head on the floor. Pt or w (with) (symbol for tion"			be progressively disciplined. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: At the monthly Quality Assurance Meeting held monthly		
	During an intervi	iew with the Director of			the results of the unusual occurrences will be reviewed.		
	Nursing on 6/06/	12 at 2:30 p.m. she			Any negative findings with a		
	indicated this inc	ident had not been			pattern the Administrator will		
	reported to the St	tate Agency, and that			assign a review team to follow		
	_	nal investigation into the			until positive results are		
		Resident D's injury.			achieved.		
		resident 2 5 mjury.					
	2. The record of on 6/05/12 at 9:1	Resident K was reviewed 5 a.m.					
	Diagnoses includ	led, but were not limited					
		osed head injury, severe					
	•	n, seizure disorder,					
		ia, and gastro-esophageal					
	reflux disease.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet Page 5 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155245	B. WIN			06/07/2	2012
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
CASTIE	TON HEALTH CAR	DE CENTED			86TH ST		
					APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL S LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		imum Data Set (M.D.S.)	+	0			BIIIE
		d 5/02/12 indicated					
		significant cognitive					
		I total staff assistance for					
	all activities of d						
		owel and bladder, and					
		*					
	received all nutr	•					
	gastrostomy tube	₹.					
	A nurgola mata di	otad 5/22/12 at 2:20 = ==					
	A nurse's note dated 5/23/12 at 2:30 p.m.						
	indicated "pt (patient) has an open area						
	· -	· · · · · · · · · · · · · · · · · · ·					
		• •					
	· ′						
	, ,	· · · · · · · · · · · · · · · · · · ·					
	· '	• •					
	to go to the hosp	ital"					
	A	Danianton and Tribana Daniant					
	dated 5/23/2012	at 3.38 p.m. indicated:					
	"Chief Complain	nt: G tube infection					
	Cinci Compian	it. G-tube infection.					
	Data: Pt (nations	nresents from ECE					
	· ·	, .					
	`	• /					
		-					
	Silicining dischar	gc					
	A physician's did	ctated "Emergency Room					
	Report dated 3/	23/12 marcaica.					
	 "History of press	ent illness: The natient is					
		-					
	swollen (symbol Called (treating) (received) order evaluation (syml (treatment). Pt d to go to the hosp An Emergency I dated 5/23/2012 "Chief Complain Data: Pt (patient (Extended Care G-tube. G-tube is smelling dischar A physician's die Report" dated 5/2 (Thistory of present the complain of the compl	id agree that pt did want bital" Department Triage Report at 3:38 p.m. indicated: Int: G-tube infection. Int: presents from ECF Facility) with infection to sepurulent with foul rege" Contact of the property of th					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 6 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155245	A. BUIL	DING	00	COMPL 06/07/	
		155245	B. WING			00/07/	2012
NAME OF P	ROVIDER OR SUPPLIER	S.			ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	TON HEALTH CAR	F CENTER			86TH ST APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID ID	7.11 02.10, 114 102.00		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	chronically hand	icappedpresents to the				•	
	Emergency Depa	artment for possible					
	G-tube infectionthere is some purulent						
	drainage						
		He has a G-tube in place.					
		what appears to be					
		re of the G-tube. There is					
		lation tissue with larged or overgrown)					
	J1 1 (me drainage which is					
		contents. There is an					
		eddened; a sign of					
	inflammation or						
		the G-tube site and					
		e lateral (to the side)					
	aspect	(
	•						
	The patient does	need G-tube care. It is					
	•	that he is not getting this					
		nave involved nursing					
	-	sic nurse to take pictures					
		d somehow to arrange					
		his gentleman. We were					
		ne G-tube site. There was					
	_	ion of the soft tissue with					
		This was removed from					
	the soft tissue. Pl	notographs were					
	obtained"						
	A hospital docum	nent titled "Flow Sheet"					
	_	dicated at these times:					
	autou 5/25/12 III	aroutou ut moso timos.					
	5:00 p.m. "ente	ered room to assess					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet Page 7 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/05/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED
	PROVIDER OR SUPPLIER		D. WII.K	STREET A 7630 E 8	DDRESS, CITY, STATE, ZIP CODE 86TH ST APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	1 ^	ozing brownish purulent site, reddened around"					
	insertion site red noted site has str pt. has dried crus red in color arous tech holding pts extreme pain who 7:35 p.m. (Forentaking pictures of at insertion site sangle straight up disk is embedded the top of disk ruwhen pt is sitting soredoctor at bof skin and area was embedded claressed with 4 x y-ed and layered from embedding During a meeting with the Director the Assistant Dir (A.D.O.N.), the lincident had not Agency as an united to the straight of t	g on 6/05/12 at 12:35 of Nursing (D.O.N.) and ector of Nursing O.O.N. indicated this been reported to the State usual occurrence, and vestigation of the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 8 of 26

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	00	COMPLI	
		155245	B. WING			06/07/	2012
NAME OF F	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE		
CASTLE	TON HEALTH CAR	E CENTER			86TH ST APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1 F	AG	DEFICIENCY)		DATE
		Resident L was reviewed					
	on 6/06/12 at 9:4	15 a.m.					
	Diagnoses include	ded, but were not limited					
	to, congestive he	eart failure, chronic					
	obstructive pulm						
	hypertension, an	-					
	A	inner Data Cat (M.D.C.)					
		imum Data Set (M.D.S.) 1 5/16/12 indicated					
		noderately cognitively					
		ed assistance with					
		ng, and was incontinent of					
	bowel and bladd						
	bower and bradd	CI.					
	A nurse's note da	ated 4/14/12 at 7:00 p.m.					
	indicated "Res (1	resident) alert this					
	shiftstated to tl	nis nurse 'There was two					
	white men/one b	lack man in his room					
	saying they was	going to kill him.' Also					
	stated he was wa	lking on water with					
	Jesus. Asked this	s nurse if did I believe					
	•	nformed Res there was					
		') men in his room					
	_	imRes. stated 'I'm not					
	lying.'						
	There were no n	urse's notes indicating					
		was reported to any					
		nanagement personnel,					
		n any investigation was					
		erventions put in place to					
	-	at L that he was safe from					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 9 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/05/2012 FORM APPROVED OMB NO. 0938-0391

	ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 155245 A. BUILDING B. WING			COMPLETED 06/07/2012	
	PROVIDER OR SUPPLIER		7630 E	ADDRESS, CITY, STATE, ZIP CODE 86TH ST IAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	A.D.O.N. on 6/0 indicated they we incident of 4/14/ indicated men ha The D.O.N. also confident the Ad of this incident, a	g with the D.O.N. and 6/12 at 3:45, both ere unaware of the 12 where Resident L d threatened to kill him. indicated she was ministrator was unaware and that it had not been tate Agency, and that no been done.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet Page 10 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPL	ETED
		155245	B. WIN			06/07/	2012
			D. ((11)	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				86TH ST		
CASTLE	TON HEALTH CAR	E CENTER			APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226 SS=D	ETC POLICIES The facility must written policies a mistreatment, ne	MENT ABUSE/NEGLECT, develop and implement and procedures that prohibit eglect, and abuse of sappropriation of resident					
	Based on record facility failed to occurrences were Agency and thor required by law a residents (Reside origin requiring law (Resident K, G-thospital treatmer allegation that m to kill him.) 3 of reporting of unus sample of 11. Findings include 1. The record of on 6/06/12 at 1:1 Diagnoses include to, cerebrovascul dementia, epilepthypertension. A significant charmony and the control of the	e reported to the State oughly investigated as and facility policy for 3 ent D, injury of unknown hospital treatment), ube condition requiring nt), (Resident L, en in his room threatened 3 residents reviewed for sual occurrences in a : Resident D was reviewed 5 p.m. ded, but were not limited lar disease, vascular sy, atrial fibrillation, and unge Minimum Data Set ment dated 4/10/12	F02	26	What corrective action(s) will accomplished for those reside found to have been affected by the deficient practice: It is this facility's policy to ensure all unusual occurrence are report to the State Agency and thoroughly investigated. Resid (D) injury is healed and suture removed. The Administrator, D.O.N., Department Heads, charge nurses and all staff have been re-educated as to follow facility's Reporting Criteria as all resident involved in a incide or accident requiring sutures must be reported to the proper state agencies. Resident (K) g-tube site has been treated for the diganosis of cellulitis. Resident (L) resident was comforted at the time and has further delusions of two white/black men in room trying to kill him while he was walking on water with Jesus. How other residents having the potential be affected by the same deficiel practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this practice. From this point on all	ed ent s /e the that ent or no one l to nt e	07/07/2012
	1. The record of on 6/06/12 at 1:1 Diagnoses include to, cerebrovasculdementia, epileps hypertension. A significant characteristic (M.D.S.) assessm	Resident D was reviewed 5 p.m. ded, but were not limited lar disease, vascular sy, atrial fibrillation, and			state agencies. Resident (K) g-tube site has been treated for the diganosis of cellulitis. Resident (L) resident was comforted at the time and has further delusions of two white/oblack men in room trying to kill him while he was walking on water with Jesus. How other residents having the potential be affected by the same deficiel practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this	no one to nt	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 11 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155245	B. WIN			06/07/2012
			В. WПV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	L.			86TH ST	
CASTLE	TON HEALTH CAR	E CENTER			APOLIS, IN 46256	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	impaired, did no	t ambulate, required staff			occurrences will be reported to	
	assistance with activities of daily living,				the State Agency and thorough	-
		ent of bowel and bladder.			investigated as required by lav	V
					The Administrator will ensure every staff member is educate	d
	Nurse's notes indicated:				on the reporting of unusual	ď
	1 varse s notes me	neated.			occurrence and what qualifies	as
	4/00/12 12:00	m " Dag (ragidant)			an unusual occurrence What	
	-	m. "Res (resident)			measures will be put into place	
		ed alarm going off.			what systemic changes will be	
		ool for "left") side of body			made to ensure that the deficient practice does not recur; An	ent
	*	cm (centimeter) 0.8 cm			in-service held June 26, 2012	
	deep skin tear no	oted on (symbol for "left")			reviewed the reporting criteria	for
	eyebrow bleedin	g. Pressure drsg			identifying and unusual	
	(dressing) applie	d stopped bleedingMD			occurrence and reporting an	
	notified N/O (ne	w order) received"			unusual occurrence. The DON	
	, the state of the	,			designee will monitor (10) cha	
	4/09/12 12·30 n	m. "Res left facility on			weekly to review all nurse's no which might include an unusua	
	•	e care hospital)."			event. These montioring will	^{XI}
	stretcher to (acut	e care nospitar).			continue until (4) consecutive	
	1/00/12 6:10 m m	"Dationt mature ad frame			weeks of 100% compliance are	e
	_	n. "Patient returned from			achived. All staff who fail to re	port
	_	cher(symbol for "left")			an unusual occurrence will be	
	eyebrow has 4 su	ıtures"			progressively disciplined. How	V
					the corrective action(s) will be monitored to ensure the deficient	ent
	A Nurse Practition	oner's Visit Note dated			practice will not recur, i.e., wha	
	4/12/12 indicated	d "Pt (patient) fell out of			quality assureance program w	
	bed 4/9 and hit h	is head on the floor. Pt			be put into place: At the month	nly
	found on the floo	or w (with) (symbol for			Quality Assurance Meeting he	
	"left") eye lacera	, , ,			monthly the results of the unus	l l
	, , , ,				occrrences will be reviewed. A	•
	 During an interv	iew with the Director of			negative findings with a patteri the Administrator will assign a	
		/12 at 2:30 p.m. she			review team to follow until pos	itive
		eident had not been			results are achieved.	
	_	tate Agency, and that				
		mal investigation into the				
	circumstances of	Resident D's injury.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet Page 12 of 26

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE S COMPL 06/07/	ETED
	PROVIDER OR SUPPLIER		70 70	630 E 8	DDRESS, CITY, STATE, ZIP CODE BOTH ST APOLIS, IN 46256	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	2. The record of on 6/05/12 at 9:1	Resident K was reviewed 5 a.m.					
	to, a history of cl mental retardation	ded, but were not limited losed head injury, severe on, seizure disorder, tia, and gastro-esophageal					
	assessment dated Resident K had s deficits, required all activities of d	owel and bladder, and tion through his					
	indicated "pt (pa' under GT site. A swollen (symbol Called (treating p (received) order evaluation (symbol	d agree that pt did want					
	dated 5/23/2012	Department Triage Report at 3:38 p.m. indicated: at: G-tube infection.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 13 of 26

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED
NAME OF I	PROVIDER OR SUPPLIER		B. WINC	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	(Extended Care I	presents from ECF Facility) with infection to s purulent with foul ge"					
	A physician's dic Report" dated 5/2	tated "Emergency Room 23/12 indicated:					
	a (age documente chronically hand Emergency Depa	ent illness:The patient is ed) year old male, icappedpresents to the artment for possiblethere is some purulent					
	There has been we essentially no car significant granu hypertrophic (enskin. There is son probably gastric erythematous (reinflammation or primarily around	He has a G-tube in place. What appears to be re of the G-tube. There is lation tissue with larged or overgrown) me drainage which is contents. There is an ddened; a sign of infection) patch the G-tube site and e lateral (to the side)					
	felt at this point t at the facility. I h supervisor, foren of the wound and	need G-tube care. It is that he is not getting this ave involved nursing sic nurse to take pictures I somehow to arrange this gentleman. We were					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 14 of 26

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 07/2012
NAME OF	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CO	DE	
CASTLE	TON HEALTH CAR	E CENTER		86TH ST APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		(X5) COMPLETION DATE
	significant invas the G-tube cuff. the soft tissue. Probtained"	ne G-tube site. There was it ion of the soft tissue with This was removed from hotographs were				
	_	dicated at these times:				
	ptG-tube site o	ered room to assess ozing brownish purulent site, reddened around "				
	insertion site red noted site has str pt. has dried crus red in color arou tech holding pts	with puss like drainage ong odor swelling noted sted drainage that is dark and site cleaned site with arm, pt appeared to be in en site touched"				
	taking pictures of at insertion site is angle straight up disk is embedded the top of disk ruwhen pt is sitting soredoctor at both of skin and area was embedded codressed with 4 x	sic Nurse) at bedside f G-tube. The plastic disk itting at a 90 degree it appears that half of d into pts (patient's) skin ibs the pts abd (abdomen) g up which has caused a edside the disk pulled out that is open where disk leaned with saline and 4's (dressings) that are around tube to keep disk				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 15 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE COMPI 06/07	ETED
		B. WING	ADDRESS, CITY, STATE, ZIP C		
NAME OF PROVIDER OR SUPPI	LIER		86TH ST	ODE	
CASTLETON HEALTH C	ARE CENTER		APOLIS, IN 46256		
	Y STATEMENT OF DEFICIENCIES	ID	,		(X5)
	EINCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE	HOULD BE	COMPLETION
`	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE
from embeddi					1
	<i>8</i>				
During a mee	ting on 6/05/12 at 12:35				
	etor of Nursing (D.O.N.) and				
	Director of Nursing				
	ne D.O.N. indicated this				
	not been reported to the State				
	unusual occurrence, and				
	l investigation of the				
	peen completed.				
	P				
3. The record	3. The record of Resident L was reviewed				
on 6/06/12 at					
Diagnoses inc	eluded, but were not limited				
-	heart failure, chronic				
' "	ılmonary disease.				
-	and chronic pain.				
Jr ,	P				
A quarterly M	Iinimum Data Set (M.D.S.)				
1 ^ -	ated 5/16/12 indicated				
Resident L wa	as moderately cognitively				
	uired assistance with				
	ving, and was incontinent of				
bowel and bla	_				
A nurse's note	e dated 4/14/12 at 7:00 p.m.				
	s (resident) alert this				
	o this nurse 'There was two				
white men/on	e black man in his room				
	as going to kill him.' Also				
	walking on water with				
	this nurse if did I believe				
	e informed Res there was				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 16 of 26

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155245	A. BUII	LDING	00	COMPL 06/07/	
		155245	B. WIN			00/07/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	TON HEALTH CAR	F CENTER			86TH ST APOLIS, IN 46256		
		TATEMENT OF DEFICIENCIES	1	ID	7.11 02.10, 117 102.00		(7/5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	(symbol for "no") men in his room					
	wanting to kill h	imRes. stated 'I'm not					
	lying.'						
	There were no no	urse's notes indicating					
	that this incident	was reported to any					
		anagement personnel,					
		n any investigation was					
		rventions put in place to					
		t L that he was safe from					
	harm.						
	During a mastine	g with the D.O.N. and					
	,	6/12 at 3:45, both					
		ere unaware of the					
	_	12 where Resident L					
		id threatened to kill him.					
		indicated she was					
		ministrator was unaware					
		and that it had not been					
	-	tate Agency, and that no					
	investigation had	• • •					
	-						
	4. An undated fa	cility document titled					
	"Reportable Unu	sual Occurrences"					
		ne D.O.N. on 6/07/12 at					
		licated to be a current					
	facility policy in	dicated;					
		ine reportable, unusual					
		e facility to insure					
	compliance with	state and federal laws.					
	Policy: Facility i	ntends to be in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet Page 17 of 26

			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155245	B. WIN			06/07/2	2012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
CASTLE	TON HEALTH CAR	E CENTER			86TH ST APOLIS, IN 46256		
				<u> </u>	Ai OLio, iii 40200		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	compliance with	the laws governing					
	-	al occurrences through					
adherence of the policy of the ISDH.							
		F					
	Procedure: Facil	ity will report unusual					
		nin 24 hours to the Long					
		ion of the ISDH of					
	alleged violation	s involving mistreatment,					
	neglect or abuse	of residents, including					
	injuries of unkno	own source and					
	misappropriation	of property."					
	An undated facil	ity document titled					
	"Investigative Pr	otocol" received from the					
	D.O.N. on 6/07/2	12 and indicated to be a					
	current facility p	olicy indicated:					
		policy of this facility to					
		ial occurrences are					
	_	oughly and timely so that					
	I -	ion as required by facility					
		n or "law" can be taken.					
		the facility to do all					
	, ,	ing with required time					
	frames."						
	2.1.29(-)(2)						
	3.1-28(c)(2)						
	3.1-28(d)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 18 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155245	B. WIN	G		06/07/	2012
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0322 SS=G	EATING SKILLS Based on the co a resident, the faresident who is for gastrostomy tube treatment and see pneumonia, diarrametabolic abnormasal-pharyngear possible, normal Based on record facility failed to gastrostomy feed accurately reflect condition and to received appropring prevent injury to insertion site, resident K) being emergency room resultant diagnos wound care, and gastrostomy tube antibiotic therapy reviewed for gas sample of 11. Findings include 1. The record of on 6/05/12 at 95 Diagnoses include	mprehensive assessment of acility must ensure that a sed by a naso-gastric or a receives the appropriate ervices to prevent aspiration rhea, vomiting, dehydration, malities, and all ulcers and to restore, if eating skills. review and interview, the ensure a resident with a ling tube was assessed to a the resident's status and ensure the resident interview to a the gastrostomy tube stulting in the resident ing sent to a hospital for treatment with a sis of cellulitis, poor infection of the erequiring treatment and y. 1 resident of 4 trostomy tube care in a	F03	22	Castleton Health Care Center respectively request an IDR be scheduled for F322 What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice; Residen (K) cellulitis (Atbx) treatment h been completed and is healed this time. How other residents having the potential to be affect by the same deficient practice be identified and what correctivaction(s) will be taken: All residents with g-tubes have the potential to be affected by this practice. The facility currently late total of four residents with G-Tubes all of the residents with g-tube sites are clean/dry intact and free from any infections. The G-Tube site is monitored to maintain the status of keeping clean dry and intact at free from infections. The facilithas implemented a q shift g-tu site review to ensure proper g-tube care is being	nts y t as at s cted will ve e nas ith ct he ery	07/07/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 19 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIVI	DDIC	00	COMPLETED	
		155245	A. BUII B. WIN	LDING		06/07/2012	
		L	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			86TH ST		
CASTLE	TON HEALTH CAR	PE CENTER			IAPOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG			
	mental retardation	on, seizure disorder,			completed. The DON or desig	nee	
	aphasia, dysphag	gia, and gastro-esophageal			will monitor all g-tube documentation twice weekly to		
	reflux disease.				ensure all monitoring and cha		
					are being completed. This	9	
	A quarterly Min	imum Data Set (M.D.S.)			monitoring will be continue		
		d 5/02/12 indicated			until (4) weeks of 100%		
		significant cognitive			compliance is achieved. What		
		total staff assistance for			measures will be put into plac		
					what systemic changes will be made to ensure that the defici		
	all activities of c				practice does not recur: At an		
		owel and bladder, and			in-service held June 26th, 201		
	received all nutr	•			the aspect of maintaining a g-		
	gastrostomy tub	e.			and keeping it clean dry and		
					intact and free from infection v	was	
	Records indicate	Resident K has had a			discussed. All Nurses at		
	gastrostomy feed	ding tube since his			Castleton have been given a		
	1 "	facility in January of			refresher course on G-Tube care. The monitoring tool was		
	1990.				also educated and implement		
	1770.				to all nurses. Any nurse who		
	A muma ala mata fa	on 5/16/12 at 2:45 m m			to follow proper procedures w		
		or 5/16/12 at 2:45 p.m.			be progressively disciplined u		
	indicated: "C.N.				and including termination. He		
		lodged g/t (gastrostomy			the corrective actions(s) will b		
		l to reinsert x 2 (times			monitored to ensue the deficient practice will not recur, i.e., wh		
	2)unable to rep	place g/t"			quality assurance program wil		
					be put into place; At the month		
	A nurse's note da	ated 5/16/12 at 3:30 p.m.			Quality Assurance Monthly	-	
		e of treating physician)			Meeting the review of all		
	,	d out to (acute care			monitoring of g-tube care will		
		ncy room)replace g/t."			discussed. Any negative patte occur the Administrator will	erns	
	nospital cilicigo	100111/10p1400 g/t.			appoint a quality review team	to	
	A hognital mbi	aion's diatotod			follow until 100% compliance		
	A hospital physi				met and retained.		
		om Report" dated 5/23/12					
	· · · · · · · · · · · · · · · · · · ·	ng to the emergency room					
	· ·	"He (Resident K) was					
	seen here a weel	ago, had the G-tube					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet Page 20 of 26

STATEMENT OF DEFICE AND PLAN OF CORRECT		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	LDING	NSTRUCTION 00	COME	E SURVEY PLETED 7/2012
NAME OF PROVIDER OF			7630 E	DDRESS, CITY, STATE, ZIP COD 86TH ST APOLIS, IN 46256	E	
PREFIX (EACH	H DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
_	is essenti	hat point, it was felt that ally no G-tube care				
indicated under G swollen Called (in (received evaluation (treatment to go to to the swollen to go to go to the swollen to go to go to go to go to go to the swollen to go	d "pt (pa T site. A (symbol treating pd) order on (symbol the hosp treating pd). Pt detection (symbol the hosp treating particular (patient) ed Care pd (pat	Department Triage Report at 3:38 p.m. indicated: at: G-tube infection. presents from ECF Facility) with infection to spurulent with foul				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 21 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155245	B. WIN			06/07/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
OAOTI E	TON LIE AL TILLOAD	E OENTED			86TH ST	
	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
IAG				TAG	BEIGENCI	DATE
		He has a G-tube in place.				
		what appears to be				
		re of the G-tube. There is				
	1 -	lation tissue with				
		larged or overgrown)				
		me drainage which is				
	1	contents. There is an				
	l • `	ddened; a sign of				
	inflammation or	· •				
	1 ^	the G-tube site and				
		e lateral (to the side)				
	aspect					
	_	need G-tube care. It is				
	_	that he is not getting this				
		have involved nursing				
		sic nurse to take pictures				
		d somehow to arrange				
		his gentleman. We were				
		ne G-tube site. There was				
	-	ion of the soft tissue with				
	the G-tube cuff.	This was removed from				
	the soft tissue. Pl	hotographs were				
	obtained"					
		nent titled "Flow Sheet"				
	dated 5/23/12 inc	dicated at these times:				
		ered room to assess				
	_	ozing brownish purulent				
	_	site, reddened around				
	site/swollen also	"				
	7:25 p.m. "assı	imed care of pt. G-tube				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet Page 22 of 26

î ´				ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI		
		155245	B. WIN			06/07/	2012	
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE			
CACTIE		E CENTED	7630 E 86TH ST INDIANAPOLIS, IN 46256					
	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE	
TAG		with puss like drainage		IAG			DATE	
		ong odor swelling noted						
		•						
	_	sted drainage that is dark nd site cleaned site with						
		arm, pt appeared to be in						
	exueme pam wn	en site touched"						
	7:35 n m (Foran	sic Nurse) at bedside						
	- '	f G-tube. The plastic disk						
	U 1	itting at a 90 degree						
		it appears that half of						
		d into pts (patient's) skin						
		ibs the pts abd (abdomen)						
	_	g up which has caused a						
		edside the disk pulled out						
		that is open where disk						
		leaned with saline and						
		4's (dressings) that are						
		around tube to keep disk						
	from embedding							
	I from emocdaing	agam.						
	7:57 n m "APS ((Adult Protective						
	_	iled on phone for PT						
	(patient)."	ned on phone for 1 1						
	(patient).							
	8:02 p.m. "(Nam	e of facility)						
	• •	ven to (name of facility						
	R.N.) R.N. aware	` -						
	contacted about	•						
	2. An undated fa	cility policy titled						
		re" received from the						
		ed to be a current facility						
		ing On 6/06/12 at 2:40 ed to be a current facility						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet

Page 23 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155245	B. WIN	G		06/07/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					86TH ST	
CASTLE	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	policy indicated:					
	_	ep G-tube site clean and				
	free of infection					
	.	1 111 1 1 1				
	<u>-</u>	are should be done daily				
		ions or infection exist. It				
		one as per physician's				
	order.					
	Procedure:					
		sess the G-tube site daily				
	for signs of infec	etion and report:				
	a. Redness					
	b. Drainage, or					
	c. Temperature					
	I -	pertinent observations				
	in the medical re	cord."				
	_	g on 6/05/12 at 12:35				
		of Nursing (D.O.N.) and				
	the Assistant Dir	· ·				
	(A.D.O.N.), Resi	ident K's record was				
	reviewed, includ	ing the following nurse's				
	notes:					
	5/19/12 6:30 a.m	ı. "(symbol for "no") s/s				
	(signs or sympto	ms) of infection at the				
	site"					
	5/20/12 11:15 a.ı	m. "Site (symbol for				
	"without") s/s of	infection"				
	5/21/12 10:30 p.1	m. "Site (symbol for				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet Page 24 of 26

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155245	A. BUILDING	00	COMPLETED 06/07/2012		
		100240	B. WING	ADDRESS CITY STATE ZID CORE	00/01/2012		
NAME OF P	PROVIDER OR SUPPLIER	L.		ADDRESS, CITY, STATE, ZIP CODE			
CASTLE	TON HEALTH CAR	E CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE		
TAG	"without") redness or drainage"		TAG		DATE		
	5/22/12 7:45 a.m. "(symbol for "no") s/s						
	of infection"						
	5/23/12 6:00 a.m. "(symbol for "no")						
	sign of infection"						
	The Assistant Director of Nursing						
	indicated she had written the nurse's note						
	of 5/23/12 at 2:3	0 documenting the					
		ident K's G-tube site and					
	sending him to the Emergency Room for						
	treatment. The A.D.O.N. also indicated						
	she had interviewed the nurses who had						
	done Resident K's G-tube care on the						
	evening of 5/22/12 and the morning of						
	5/23/12 and both indicated they had not						
	noted any concer	rns with the G-tube site.					
	The hospital Forensic Nurse's						
	photographs of Resident K's G-tube site						
	obtained at the Emergency Room and						
	documenting the condition of his G-tube						
	site on admission were reviewed. Both the						
	D.O.N. and the A.D.O.N. indicated they						
	could offer no explanation as to the						
	apparent conflict between the facility's						
		f Resident K's G-tube					
		d that documented in					
	-	and photographs, or how					
		uld have developed in the					
		e nurse's note of 5/23/12					
		his discharge to the					
hospital for treatment at 2:30 p.m.							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet Page 25 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/05/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155245		A. BUILDING B. WING		COMPLETED 06/07/2012		
	VIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	.1-44(a)(2)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: H4XE11

Facility ID: 000149

If continuation sheet Page 26 of 26